3846

BUREAU OF VITAL STATISTICS

ARIZONA STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 045

Registered No. #2

1. PLACE OF DEATH

County Cochise State Arizona

District or Township St Davis of Village St Davis or

City ..... No. ..... St., ... Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number).

2. FULL NAME Julia May Forrest 2210

(a) Residence. No. ..... St., ... Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR or RACE	5. SINGLE, MARRIED, WIDOWED or DIVORCED. (Write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 15, 1935

7. AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) St Davis

(State or country) Arizona

PARENTS

10. NAME OF FATHER John Allen Forrest

11. BIRTHPLACE OF FATHER Ohio (city or town)

(State or country) California

12. MAIDEN NAME OF MOTHER Mary Jane Gordon

13. BIRTHPLACE OF MOTHER Texas (city or town)

(State or country) Arizona

14. Informant Mary Jane Forrest

(Address) St Davis Ariz

15. Filed 4-10-, 1935 Arnold Christensen Registrar.

3 22669

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 15 1935
Month Day Year

17. I HEREBY CERTIFY, That I attended deceased from

....., 19..... to ....., 19.....,

that I last saw her alive on March 15, 1935

and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Don't Know

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. A. Morrison, M. D.

March 16 1935 (Address) Bowen

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Davis	3-16-35
20. UNDERTAKER Family & Friends	ADDRESS -